2022 Workers' Compensation Seminar

March 23-25, 2022

THE EVOLUTION OF MEDICARE COMPLIANCE AND ITS ASSOCIATED SPECTRUM OF RISK

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Workers' Compensation in the Garden of Good, and Evil?

ALFA INTERNATIONAL 2022 WORKERS' COMPENSATION SEMINAR

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JW MARRIOTT PLANT RIVERSIDE DISTRICT
SAVANNAH, GEORGIA

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Finding the Right Balance of Risk and Cost in the Evolving World of Medicare Compliance

Overview

- Not a Medicare 101 discussion
  - We assume:
    - Attendees have basic understanding of Medicare Involvement in WC
      - See Appendix for authority
    - Attendees have established programs for Medicare compliance, e.g., §111 Reporting, Conditional Payments and Protection of Medicare's future interests (MSAs)
- It **is** a discussion to address:
  - Most significant recent developments
  - Risk management strategies to take ownership of risk and realize financial savings re Medicare's interest in settlement of future medical

Things to Keep on Your Radar

- CMS sent Final Rule for Section 111 Civil Monetary Penalties to the Office of Management and Budget for Review and approval. Now is the time to assess the health of your Section 111 Reporting program.
- Proposed Rule regarding Future Medicals for liability, workers' compensation and no-fault.

Protecting Medicare's Interests in Future Medical

- **Quick Review:**
  - Obligation to "reasonably"/"adequately" protect Medicare's interest when closing out future medical
    - All that's required is a reasonable allocation to pay for future Medicare-covered, work-related medical expenses
  - Submission of an MSA to CMS is a voluntary process
    - CMS will review only if a Workload Review Threshold is met
    - Workload Review Thresholds are not a safe harbor

Traditional MSA Approach and the Associated Risks

- The WCMSA Reference Guide provides that with regard to Medicare's interests, the parties must:
  - "**adequately** address", "**adequately** protect", "**adequately** consider", "**reasonably** consider", "give **reasonable** recognition to", or "**reasonably** anticipated future medical needs".
- In reality, CMS's approach is more akin to what medical care might **possibly** be required.
  - Risk of overfunding

The Risks if Medicare Asserts its Interests were not Adequately Protected

- Exhaustion of Settlement Proceeds before Medicare will Pay Medical Expenses
- CMS claims for Reimbursement
  - From Employers/Insurers
  - From Employees

Defining Your Risk—Exhaustion of Settlement Proceeds

- If a settlement closes future medical and Medicare's interests were not "reasonably considered" what are CMS' remedies?
  - WCMSA Reference Guide section 4.3
    - As a matter of policy and practice, CMS will **deny payment** for medical services related to the WC injuries or illness requiring attestation of appropriate exhaustion equal to the total settlement less procurement costs before CMS will resume primary payment obligation for settled injuries or illnesses."

Defining Your Risk—Exhaustion of Settlement Proceeds

- **How does this translate into risk to the employer/insurer?**
  - If the terms of settlement require, or state law requires, the employer/insurer to pay post-settlement medical bills if Medicare refuses, or
  - If the terms of the settlement provide, or state law provides, that the employee may reopen the settlement, if Medicare refuses to pay the employee's medical bills.
- Absent that, the only possible risk to the employer is if Medicare **does** make payments post-settlement without requiring the employee to exhaust the full amount of the settlement, resulting in Conditional Payments.
  - That's what is asserts it will **not** do
  - And in non-beneficiary cases, how does Medicare find out about the settlement?

Defining Your Risk—Exhaustion of Settlement Proceeds

- **How does this translate into risk to the employer/insurer?**
  - If the terms of settlement require, or state law requires, the employer/insurer to **reimburse the employee** if Medicare obtains reimbursement from employee, or
  - If the terms of the settlement provide, or state law provides, that the employee may **reopen the settlement**, if Medicare seeks reimbursement from the employee.

Defining Your Risk—CMS' Recovery from Employers/Insurers

- 42 U.S.C. 1395y(b)(2)(B)(ii) and Section 1862(b)(2)(B)(ii) of the Social Security Act
  - a primary plan . . . shall reimburse the appropriate Trust Fund for any payment made by the Secretary under this subchapter with respect to an item or service if it is demonstrated that such primary plan . . . **had a responsibility to make payment** with respect to such item or service.

Defining Your Risk—CMS' Recovery from Employers/Insurers

- 42 U.S.C.§1395y(b)(3)(A)
  - There is established a private cause of action for damages (which shall be in an amount double the amount otherwise provided) in the case of a primary plan which fails to provide for primary payment (or appropriate reimbursement) in accordance with paragraphs (1) and (2)(A).
- 42 C.F.R. 411.24(e)
  - ***Recovery from primary payers.*** CMS has a direct right of action to recover from any primary payer.

Defining Your Risk—CMS' Recovery from Employers/Insurers

- The Elephant in the room:
  - Has CMS ever filed suit against an employer/insurer after settlement for post-settlement medical payments by Medicare?
  - Has CMS ever threatened reimbursement from an employer/insurer after settlement for post-settlement medical payments by Medicare?

Alternatives to Traditional MSA and Risks of Each

Do Nothing to Protect Medicare's Interest:

- General Release—no allocation for future medical
  - Benefits
    - No delays
  - Risks
    - Employee:
      - "Medicare may also refuse to pay for future medical expenses related to the WC injury until the entire settlement is exhausted." WCMSA Reference Guide Section 3.0
      - Reimbursement of CMS
    - Employer:
      - Possible post-settlement conditional lien (after entire settlement is exhausted by employee)
      - Possible action by employee to set-aside settlement
        - If State law or settlement terms provide for it
      - CMS claim for Reimbursement
  - Risk Tolerance Factors:
    - Beneficiary or not?
    - Workload Review Thresholds met or not?
    - Amount of settlement.

Risk Assessment of Common Situations

- Medicare beneficiary, settlement for $50k, and no allocation for future medical, and non submission
- Risk Analysis
- Options to minimize risks?

Risk Assessment of Common Situations

- Non-beneficiary, reasonable expectation will become one in 30 months, settlement for $249,800 and no allocation.
- Risk Analysis
  - Would it matter if settlement for $24,900
- Options to minimize the risks?

Alternatives to Traditional MSA and Risks of Each

Non-Submission of traditional MSA following CMS standards:

- Following CMS Standards (commutation)—cookie cutter
  - Benefits:
    - Avoids CMS delays or increase in allocation
  - Risks (without vendor hold harmless or indemnification agreement):
    - Employee:
      - CMS may claim allocation is insufficient as it is not a “reasonable” allocation and deny payments of bills until total amount of settlement is exhausted
      - CMS claim for reimbursement
    - Employer:
      - Potential over-inflated MSA amount
      - Payment of medical bills, if state law or settlement terms allow for that
      - Action for reimbursement by CMS or private cause of action

Alternatives to Traditional MSA and Risks of Each

Non-Submit evidence-based medicine/standards of care allocation

- Benefits:
  - Increases ability to settle the medical portion of claim
  - More reasonable allocation, not a cookie cutter approach
    - 35-40% savings v. CMS methodology
      - Based upon:
        - What is probable, not what is possible
        - Claimant's utilization patterns and medical standards
        - Review of medical treatment recommendations of treating providers
  - Post-settlement support and protections by vendor
- Risks (without vendor hold harmless or indemnification agreement):
  - Employee:
    - Required exhaustion of entire settlement before Medicare pays medical bills
    - Reimbursement action by CMS or private cause of action
  - Employer:
    - Payment of medical bills if state law or settlement terms allow for it
    - Action for reimbursement by CMS or private cause of action

WCMSA Reference Guide: Section 4.3 “The Use of Non-CMS-Approved Products to Address Future Medical Care”

- A number of industry products exist with the intent of indemnifying insurance carriers and CMS beneficiaries against future recovery for conditional payments made by CMS for settled injuries. Although not inclusive of all products covered under this section, these products are most commonly termed “evidence-based” or “non-submit.” 42 C.F.R. 411.46 specifically **allows CMS to deny payment for treatment of work-related conditions if a settlement does not adequately protect the Medicare program’s interest.** Unless a proposed amount is submitted, reviewed, and approved using the process described in this reference guide prior to settlement, CMS cannot be certain that the Medicare program’s interests are adequately protected. As such, **CMS treats the use of non-CMS-approved products as a potential attempt to shift financial burden by improperly giving reasonable recognition to both medical expenses and income replacement.** As a matter of policy and practice, CMS **will deny payment for medical services related to the WC injuries or illness** requiring attestation of appropriate exhaustion **equal to the total settlement less procurement costs before CMS will resume primary payment** obligation for settled injuries or illnesses. This will result in the claimant needing to demonstrate complete exhaustion of the net settlement amount, rather than a CMS-approved WCMSA amount.

In other words . . .

- When “evidence-based” or “non-submits” are used rather than submitting WCMSA to CMS for approval, CMS:
  - Will treat it as a **potential attempt to shift financial burden by improperly giving reasonable recognition**
  - Will not pay for medical care for Medicare covered, work-related expenses:
    - **Until claimant** attests
      - **That the total settlement, less procurement costs, has been used to pay for Medicare covered, work-related treatment**

Dear

The Centers for Medicare & Medicaid Services (CMS) received a letter stating that you and settled a workers' compensation matter on 11/17/2021 for an incident that occurred on or about 11/30/2017. The letter notes that you and agreed to set aside a certain amount for your future medical care related to the workers' compensation illness or injury, but decided to forgo CMS' established Workers' Compensation Medicare Set-Aside Arrangement (WCMSA) review process for this settlement.

Section 1862(b)(2)(A) of the Social Security Act prohibits the Medicare program from making payment where payment was made or may reasonably be expected to be made by another party. 42 C.F.R. 411.46 specifically allows Medicare to deny payment for treatment of work-related conditions if a settlement does not "adequately protect Medicare's interest"—that is, does not include enough money to pay for treatment of those conditions. Because you did not seek prior review and approval by CMS of the amount set aside in your settlement for your future medical care, Medicare will not pay for the treatment of your work-related condition until you have demonstrated the appropriate exhaustion of your "net" settlement proceeds. Please review the enclosed package for information about the submission of annual attestations. Once you have shown that the settlement proceeds (total settlement amount minus procurement costs such as attorney fees, and minus funds repaid to Medicare for care prior to the date of settlement) have been exhausted, Medicare will make payment again. If you have questions about this letter, please call RO-09 CUSTOMER SERVICE at (415) 744-3658.

Unanswered Questions . . .

- How is this reconciled with Section 8.0 of the WCMA Reference Guide, Version 3.5, which states:
  - “There are no statutory or regulatory provisions requiring that you submit a WCMSA amount proposal to CMS for review.”
- Is this a “strict liability” standard, where there is no opportunity to demonstrate that Medicare’s interests were “reasonably” or “adequately” protected/considered?
- If not, what is the mechanism/procedure by which to demonstrate that Medicare’s interests were “reasonably” or “adequately” protected/considered?
- How does this section apply to WCMSAs that do not meet a Workload Threshold?

Risk Tolerance Drives Policy—One Approach

We have discussed _____'s current MSA program internally and externally. As it stands, this is CMS's position; they do not (and will not) recognize non-submit MSAs. And as a "policy and practice" they will be denying medical payment for treatment post settlement. Unfortunately, this leaves _____ at risk. CMS is already sending out denial letters to claimants that have non-submit MSAs. I've talked with multiple other employers that have already been alerted by their claimants.

Effective immediately, we are going to suspend the use of non-submit Medicare Set-Asides (MSAs) and all workers' compensation claims that require an MSA will need to be submitted for CMS approval.

For any claim that settlement has been signed, but waiting on state approval, those will proceed as they currently are.

For any claim that has not yet settled or is in negotiations, we will need to have the MSA approved by CMS.

We will need to discuss our next steps to ensure we are getting an MSA at the right time, with the files positioned correctly so that CMS is not coming back with a higher amount. We can set up some time next week if you and the team are available.

Corporate Claims Manager

Risk Assessment of Common Situations

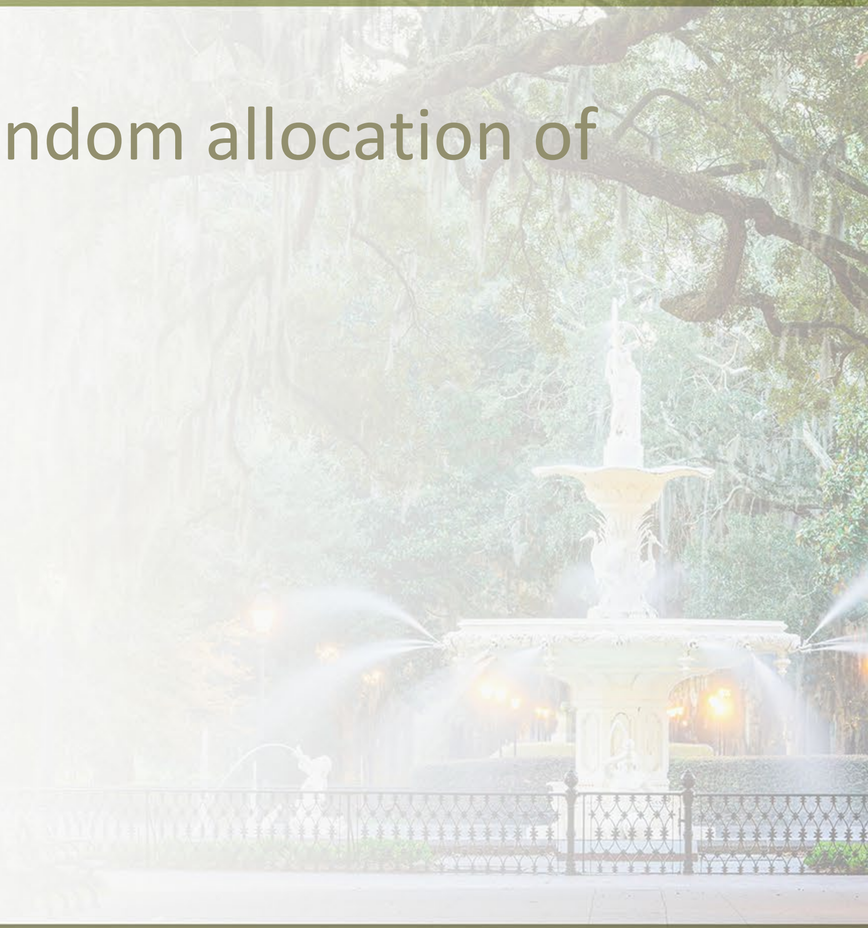
- Settlement of claim with beneficiary for $50k, and use of non-submit, evidence-based MSA to be funded with $60k, and certification. Traditional MSA approach estimated $100k for MSA, and CMS might require more if submitted.
- Risk Analysis
- Options to minimize risk

Risk Assessment of Common Situations

- Beneficiary, compensable claim, settlement for $50k for indemnity and $20k for medical. Future medical allocation is just a number, not really based on any analysis of future medical. Not submitted.
- Risk Analysis.
- Options to minimize the risks?

Risk Assessment of Common Situations

- Beneficiary, settlement for $24k, out of which random allocation of $5k for future medical is made, not submitted.
- Risk Analysis
- Options to minimize the risks?



Risk Assessment of Common Situations

- Compensable claim, non-beneficiary, no reasonable expectation will become beneficiary in 30 months and settlement of $260 for indemnity and $60k for future medical. Parties base future medical on opinions of physicians of reasonable future medical care.
- What are the risks?
- Options to minimize the risks?

Risk Assessment of Common Situations

- 56 year old non-beneficiary, and has not applied for SSDI, and claimant doesn't intend to.
- Pain physician has recommended SCS, and claimant has repeatedly refused.
- Extent of disability hotly contested; value between $90,000 and $400,000.
- To fund an MSA using traditional CMS approach results in allocation of $175,000, preventing settlement.
- Settlement for $210,000 and allocation $25,000 for non-SCS expenses.
- What are the risks?
- Options to minimize the risks?

Risk Assessment of Common Situations

- Disputed claim with beneficiary. Extent of disability disputed. If Claimant prevails, value is $520,000. If Defendant prevails, value is $115,000.
- Whether future surgery is work-related is disputed. Estimated cost is $80,000. If Medicare pays for it, estimated cost is $22,000.
- Settled for $140,000 to resolve past and future indemnity. Settlement does not close out future medical, and leaves dispute unresolved.
- Claimant plans to obtain future treatment with Medicare.
    - The employer/insurer agrees it will address any future Medicare claims for reimbursement of post-settlement Conditional Payments.
- What are the risks?

Alternatives to Traditional MSA and Risks of Each

Apportionment based on Compromise (compensability denials):

- Allocate portion of settlement to future medical based on ratio of the amount of indemnity paid to the amount of indemnity that would have been payable if compensable
- Legal basis
  - 42 CFR 411.46 and 411.47
  - SSR 70-38
- Benefits
  - Substantially less to resolve claim
  - Risks (without vendor hold harmless or indemnification agreement):
    - CMS says the statute relates to Conditional Payments, not MSAs
    - Any reported decisions????

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THE END

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Appendix

Medicare Secondary Payer Act, 42 U.S.C. 1395y(b)(2)(A)

- “Medicare may not pay for a beneficiary's medical expenses when payment “has been made or can reasonably be expected to be made under a workers’ compensation plan, an automobile or liability insurance policy or plan (including a self-insured plan), or under no-fault insurance.”

Medicare Secondary Payer Act, 42 U.S.C. 1395y(b)(2)(B)

- Conditional payment
  - (i)Authority to make conditional payment
    - The Secretary may make payment under this subchapter with respect to an item or service if a primary plan described in subparagraph (A)(ii) [4] has not made or cannot reasonably be expected to make payment with respect to such item or service promptly (as determined in accordance with regulations)…"
  - (ii)Repayment required
    - Subject to paragraph (9), a primary plan, and an entity that receives payment from a primary plan, shall reimburse the appropriate Trust Fund for any payment made by the Secretary under this subchapter with respect to an item or service if it is demonstrated that such primary plan has or had a responsibility to make payment with respect to such item or service. A primary plan's responsibility for such payment may be demonstrated by a judgment, a payment conditioned upon the recipient's compromise, waiver, or release (whether or not there is a determination or admission of liability) of payment for items or services included in a claim against the primary plan or the primary plan's insured, or by other means.

Section 8.0 of the WCMA Reference Guide, Version 3.5:

"There are no statutory or regulatory provisions requiring that you submit a WCMSA amount proposal to CMS for review. If you choose to use CMS' WCMSA review process, the Agency requires that you comply with CMS' established policies and procedures in order to obtain approval."

4.3 The Use of Non-CMS-Approved Products to Address Future Medical Care

- A number of industry products exist with the intent of indemnifying insurance carriers and CMS beneficiaries against future recovery for conditional payments made by CMS for settled injuries. Although not inclusive of all products covered under this section, these products are most commonly termed “evidence-based” or “non-submit.” 42 C.F.R. 411.46 specifically allows CMS to deny payment for treatment of work-related conditions if a settlement does not adequately protect the Medicare program’s interest. Unless a proposed amount is submitted, reviewed, and approved using the process described in this reference guide prior to settlement, CMS cannot be certain that the Medicare program’s interests are adequately protected. As such, **CMS treats the use of non-CMS-approved products as a potential attempt to shift financial burden by improperly giving reasonable recognition to both medical expenses and income replacement.** As a matter of policy and practice, CMS **will deny payment for medical services related to the WC injuries or illness** requiring attestation of appropriate exhaustion **equal to the total settlement less procurement costs before CMS will resume primary payment** obligation for settled injuries or illnesses. This will result in the claimant needing to demonstrate complete exhaustion of the net settlement amount, rather than a CMS-approved WCMSA amount.

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Workers' Compensation Medicare Set-Aside (WCMSA) Reference Guide, 3.3, COBR-Q2-2021-v3.3

- Section 1.0 About This Reference Guide
  - "There are no statutory or regulatory provisions requiring that you submit a WCMSA amount proposal to CMS for review. If you choose to use CMS' WCMSA review process, the Agency requests that you comply with CMS' established policies and procedures."
- 4.2 Indications That Medicare's Interests are Protected
  - "Submitting a WCMSA proposed amount for review is never required. But WC claimants must always protect Medicare's interests…"
  - "Without CMS' approval, Medicare may deny payment of [work-]related medical claims, or pursue recovery for [work-]related medical claims that Medicare paid up to the full amount of the settlement, judgment, award, or other payment."

42 CFR 411.46(d)

- Basic rule. Except as specified in paragraph (d)(2) of this section, if a lump-sum compromise settlement forecloses the possibility of future payment of workers' compensation benefits, medical expenses incurred after the date of the settlement are payable under Medicare.
- Exception. If the settlement agreement allocates certain amounts for specific future medical services, Medicare does not pay for those services until medical expenses related to the injury or disease equal the amount of the lump-sum settlement allocated to future medical expenses.

42 CFR 411.47 Apportionment of a lump-sum compromise settlement of a workers' compensation claim

- (a) ***Determining amount of compromise settlement considered as a payment for medical expenses.***
  - **(1)** If a compromise settlement allocates a portion of the payment for medical expenses and also gives reasonable recognition to the income replacement element, that apportionment may be accepted as a basis for determining Medicare payments.
  - **(2)** If the settlement does not give reasonable recognition to both elements of a workers' compensation award or does not apportion the sum granted, the portion to be considered as payment for medical expenses is computed as follows:
    - **(i)** Determine the ratio of the amount awarded (less the reasonable and necessary costs incurred in procuring the settlement) to the total amount that would have been payable under workers' compensation if the claim had not been compromised.
    - **(ii)** Multiply that ratio by the total medical expenses incurred as a result of the injury or disease up to the date of the settlement. The product is the amount of the workers' compensation settlement to be considered as payment for medical expenses.